the attention of health providers who may have an obligation to report the problem.

Over the past ten years most states have adopted mandatory reporting laws for elder abuse. Definitions of abuse and reporting requirements may vary from state to state, but many are patterned after those developed in California. Although elder abuse is broadly defined in California to include physical abuse, neglect, mental abuse, and exploitation, only physical abuse that includes battery, sexual assault, and unreasonable physical restraint has a mandatory reporting requirement. Other forms of abuse may be reported, but there is no legal requirement to do so.

Instances of elder abuse may be reported to the police or to the county adult protective services office nearest the victim's residence. Some counties in California have "elder abuse hotlines" to provide information or take reports. All telephoned reports must be followed up by a written report using an elder-abuse reporting form, which should be available in hospital social work offices or from adult protective services offices. Anyone who reports elder abuse is immune from any criminal or civil actions, and failure to report physical abuse can result in a fine, imprisonment, or both.

Caring for victims of elder abuse is generally a team effort. A careful medical evaluation and the identification of factors that led to the abusive situation by a trained social worker are important. Reporting elder abuse is an important first step in providing relief for the victim, mobilizing community resources, and documenting what promises to be a growing problem.

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Treatment of Chronic Pain With Psychotropic Drugs

THE USE OF psychotropic drugs in the management of chronic pain is widespread. The associated symptoms of depression, anxiety, and agitation that often accompany the principal physical symptom of pain have naturally led to the use of antidepressant and tranquilizing agents. In a recent survey, tricyclic antidepressants were used by nonpsychiatric physicians 30% of the time for pain compared with 56% for treating depressions.

Many other psychotropic drugs, such as the neuroleptics, chlorpromazine and lithium carbonate, have been used enthusiastically but with varying results. Monoamine oxidase inhibitors are effective, but their use is limited by substantial food and drug interactions. Only the tricyclic antidepressants have routinely proved effective. In numerous clinical trials these medicines produce a measurable improvement in patient functioning and pain reduction of about 66% compared with 33% for placebo. Even cortical evoked potentials in experimentally produced pain in human subjects responded as well to the use of imipramine hydrochloride as to meperidine hydrochloride.

The possible mechanism of action to account for the success of the antidepressants has been reviewed. Many think that chronic pain is simply a depression-equivalent disorder

and therefore responsive to the use of antidepressants. Studies with animal models, however, have shown the potent analgesic properties of these drugs.

For treatment, the more serotonergic antidepressants such as amitriptyline hydrochloride, imipramine hydrochloride, and doxepin hydrochloride are preferred by most clinicians. The fact that these drugs are sedating can be used to great advantage when they are given at bedtime. Some patients will prefer the adrenergic antidepressants such as desipramine hydrochloride and nortriptyline hydrochloride. The usual dose varies from 25 mg to 100 mg at bedtime. Trazodone hydrochloride, a nontricyclic antidepressant with minimal anticholinergic side effects, has been used with excellent results in more than 200 patients.

Primary care providers must not expect any psychotropic medicine by itself to treat chronic pain. Success requires a comprehensive management of the whole patient and a thoughtful tactical plan emphasizing patients' active participation.

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Social Rehabilitation of Schizophrenia

PSYCHOSOCIAL REHABILITATION has been shown to augment antipsychotic medication regimens in improving the course and outcome of schizophrenia. Antipsychotic medication can diminish symptoms—especially the specific symptoms of the disorder—and rehabilitation efforts can reduce or compensate for social and occupational disability and handicaps. Rehabilitation strategies assume two forms: educational and skill-building methods to increase patients' behavioral repertoires, and supportive methods to buffer the stressful effects of environmental demands and to provide social aids for overcoming disabilities.

Social skills training has been used in both hospital and community settings to facilitate patients' acquiring and maintaining interpersonal behaviors. Using instructions, modeling, behavioral rehearsal, feedback, and homework, a wide range of interpersonal and coping skills can be taught in a modular format with prescribed content areas and learning exercises. A skills training module consists of a trainer's manual, a patient's workbook, and a professionally produced videotape for demonstrating the desired skills. Because they are highly structured and prescriptive in their methods, modules can be used by an array of professionals and paraprofessionals to teach such relevant skills as medication self-management, symptom self-management, grooming and self-care, social problem solving, family coping, and conversation. Specific skills are taught; for instance, in medication management, patients learn the therapeutic and side effects of neuroleptic medication, how to monitor drug benefits and side effects, and how to negotiate medication issues with a physician. Skills training has been useful in vocational rehabilitation—that is, training participants in job-finding and job-maintenance skills.

Strategies have been developed to improve the family's

interactions with a schizophrenic patient, thereby decreasing the family burden and enhancing the patient's support network. Behavioral family management begins with factual discussion and education regarding the causes and characteristics of the disease. The effects of medication are discussed, and the family is enlisted in gaining a patient's cooperation with administering drugs. Families are subsequently trained in communication skills that can improve the emotional climate at home and to equip all family members with the problem-solving skills required to modulate stressors in the future. ("Modules for Training Social and Independent Living Skills" can be obtained from Psychiatric Rehabilitation Consultants, Camarillo-UCLA Research Center, Box A, Camarillo, CA 93011.)

Case management that bolsters strained support networks provides a fixed and continuous point of responsibility for professional care-giving and an orchestration of a broad spectrum of medical and psychiatric treatment, social services, and rehabilitation efforts. Case managers can aid the patients' course through the red tape of various agencies and coordinate the implementing of treatment by various service providers. Good case management is longitudinal, following a patient into and back out of the hospital, thereby continuing a person's links with family, professional, and community support services.

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Pharmacologic Treatment of Cocaine Dependence

THE GROWING INTEREST in the pharmacologic treatment of cocaine dependence reflects the often disappointing results obtained with current psychosocial treatment approaches such as group and individual psychotherapy, behavior modification, and Cocaine Anonymous. Various pharmacologic agents are being used to try to improve the effectiveness of psychosocial treatment, usually based on neurochemical theories of the action of cocaine. No pharmacologic agent has yet been subjected to extensive, rigorous clinical trials, so there is little sound empiric evidence to support the use of any pharmacologic agent in the treatment of cocaine dependence or to suggest the optimal duration of treatment. A prudent physician must balance the possible benefits of pharmacologic treatment against the possible risks, which include medication side effects, toxic interactions with cocaine if a patient relapses, and distracting a patient from the psychosocial aspects of treatment.

The most popular pharmacologic treatment approach is the use of cyclic antidepressants, which mimic the action of cocaine in blocking presynaptic neurotransmitter reuptake. These agents were first tried during the acute withdrawal phase because of the depression and anhedonia—inability to experience pleasure—common among newly admitted cocaine addicts. Although this depression is due to the cocaine dependence itself and therefore would resolve with abstinence alone, a longer term course of antidepressant medica-

tion is often useful in treating cocaine dependence. The therapeutic effect takes one to two weeks to develop and requires doses and blood levels similar to those for antidepressant action. Most patients can tolerate a rapid upward titration from the starting dose—25 to 50 mg per day—over four to seven days.

In a recently published double-blind, placebo-controlled study in outpatient cocaine addicts, administering desipramine hydrochloride—2.5 mg per kg of body weight daily—significantly reduced the craving for cocaine and cocaine use over a six-week treatment period. Several nonblind studies have also found the use of desipramine effective. There is no a priori reason why desipramine should be the only effective cyclic antidepressant, and there is anecdotal evidence that others, such as trazodone hydrochloride, imipramine hydrochloride, maprotiline hydrochloride, and fluoxetine hydrochloride, are also effective.

Another popular pharmacologic treatment approach is the use of dopamine-agonist agents such as bromocriptine mesylate and amantidine hydrochloride. The rationale for these is that their use alleviates the presumed hypodopaminergic or dopamine depletion state caused by long-term cocaine use. They may have a quicker onset of action than the cyclic antidepressants and so may be more useful during the acute withdrawal phase. A few small-scale, short-term, double-blind studies and several longer nonblind trials have found these two agents effective, but large-scale, placebo-controlled studies are just now being conducted. The effective dosage of amantidine appears to be in the same range used in treating natural or neuroleptic-induced parkinsonism—that is, 100 to 200 mg twice a day. Bromocriptine seems to be active at much lower dosages—1.25 to 7.5 mg a day in divided doses. Its use has also been reported effective in adults whose cocaine use represents self-medication for residual attention deficit disorder. One problem with bromocriptine therapy is poor patient compliance because of headache and nausea unless the dose is gradually titrated upwards over one to two weeks. Some interest has developed in the anticonvulsant carbamazepine, based on the hypothesized role of kindling in mediating cocaine effects. In a recently published, open-label clinical series, substantial decreases were reported in cocaine craving and use among outpatients taking carbamazepine, 200 to 800 mg daily.

Other pharmacologic treatments that have been tried, but for which there is little or no scientific evidence, include monoamine oxidase inhibitors, lithium carbonate, stimulants, neuroleptics, and amino acids. The use of lithium (at blood concentrations of 0.5 to 1.2 mEq per liter) may be helpful in cocaine addicts with primary bipolar or cyclothymic disorder, but it is of little benefit in others. Stimulants such as methylphenidate and amphetamine have a high abuse potential, and their use should be avoided in cocaine addicts. Neuroleptics, being dopamine receptor antagonists, block the psychotic manifestations of acute cocaine intoxication and theoretically would be useful; in fact, they apparently do not reduce the euphoric, reinforcing effects of cocaine. Amino acids such as tryptophan, 1 to 2 grams daily; tyrosine, 1 to 3 grams daily; and levodopa, 0.5 to 1 gram daily, are cheap, presumably safe, and widely marketed in proprietary mixtures, but their use has not yet been subjected to controlled studies.

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